DIVISION OF
DEVELOPMENTAL
DISABILITIES

Division Guideline #8

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Title: **Transition Guidelines**

Application: **State-Operated Program Campuses, Regional Offices, and Community Providers**

The Division of Developmental Disabilities is committed to providing supports to individuals in the most integrated setting appropriate to their needs. This guideline encompasses the processes used to assist individuals who reside at State-Operated Program campuses to successfully transition to living in the community of their choice.

1. Information and Education

Providing information and education to individuals, families, guardians and staff is a key step in the successful transition of individuals from State-Operated Program campuses to the community.

State-Operated Program campuses have developed proactive methods of providing information about transition options to individuals, families and guardians which may include the following:

- Developing and sharing success story brochures
- Sharing videos such as “Good Golly Miss Molly”
- Offering an opportunity to meet 1:1 with another individual, family, or guardian who has experienced transition

- Offering presentations at meetings such as Parent Organization meetings on topics such as:
  A. Self-Directed Supports
  B. Inviting individuals, family members and guardians of individuals who have transitioned to a community provider to share their experiences
  C. Inviting individuals, family members and guardians of individuals who have transitioned to a State-Operated Program in the community to share their experiences
- Organizing provider fairs for individuals, families, guardians, and staff to meet community providers and learn about the services and supports they provide
- Partnering with advocacy groups to disseminate information about transition

State-Operated Program campuses have also provided trainings to staff involved in transition on topics such as:

- Transition process
- Risk management
- Home ownership
- Self Directed supports
- Provider presentations on supports and services they provide
- Shared Living

2. Preliminary Planning

Division Directive 4.170 describes the Discharge Planning Process. A Placement Plan Document is developed for all individuals residing at State-Operated Program campuses at the time of the annual review.

Transition project planning teams meet on a regular basis to review progress and maintain focus on transitioning individuals to the community. State-Operated Program campus staff and Transition Coordinators periodically contact individuals, families, and guardians to discuss options for transition to the community. Methods of contact and follow-up may include:

- Developing a priority list of individuals for transition. The State-Operated Program campus staff and the Transition Coordinator contact these individuals, their families and guardians to discuss transition options including residential, employment and/or day supports, self-directed supports, and availability of other services the individual may need; explain how the transition process works, explain the referral system, provide information about the Medicaid Waiver, etc., and answer any questions the guardians may have
- Meeting with interested individuals, families, and guardians to discuss transition options and/or tour community providers
- Providing video tapes of available homes to individuals, families, and guardians.
- Maintaining a tracking list to document the response of the individual, family, and guardian to discussion of transition opportunities
- Mailing information to individuals, families, and guardians on a quarterly basis so that the following is provided throughout the course of a year: The Placement Plan, Olmstead Fact

Sheet, lists of community providers, residential placement options, Finding a Provider brochure, and Medicaid Waiver Fact Sheet
- Sharing informational brochures from various providers with individuals, families and guardians

3. Transition Process

Once an individual, family, or guardian has made a decision to pursue community transition, Division Directive 4.270 describes the transition process which includes:
- use of the referral database to connect individuals seeking residential providers with providers in their selected area
- encouraging individuals and families to review profiles of potential support providers available on the Department of Mental Health website
- ensuring choice of providers and service options
- risk mitigation planning
- ensuring a functional behavioral assessment and development of behavioral support strategies are completed, if needed, and community provider staff are provided competency based training in behavioral support strategies designed for the individual
- scheduling visits to the new home by the individual, family, and guardian
- scheduling times for community provider staff to shadow staff at the State-Operated Program campuses
- coordination of transition meetings and development of the transition plan

Individuals, their families, guardians, and advocates or friends identified by the individual, family, or guardian are encouraged to actively participate throughout the transition process. This may include visiting and selecting potential homes, providing input into the development of new homes, selection of housemates, selection of new staff and medical providers, and all aspects of developing the transition plan.

Funding for supports that the individual needs to be successful in the community is provided through Money Follows the Person, the Medicaid Waiver, and general revenue.

4. Support Planning

The team will develop with the individual a Transition plan. The objective of the plan is to provide the individual appropriate and adequate supports for health and safety and their wishes, and to minimize difficulty in adjusting to any changes in his/her life that may occur with the change in living arrangements or supports.

The plan will include a risk assessment of the previous support situation and the new support situation with risk mitigation strategies including a crisis safety plan for potential challenging behaviors.

The plan will include the sharing of history and information with the new support persons, including childhood care, strategies of support, services and placements and medical history.

The plan will include that the individual and support persons' meet face to face at least one time prior to the change in support locations and that the individual will have the opportunity to visit the new location prior to the final decision to move.

The plan will include training of new support persons' in individual strategies of support and crisis safety plan.

The plan will include securing auxiliary services such as behavior resource team assistance, person centered strategies consultation and/or behavior analysis services to develop strategies and training for the new support provider if behavioral challenges occurred in the previous support situation**.**

The plan will include strategies to maintain important relationships between the individual and peers, professionals, and natural supports in the new support location with regular frequent contact opportunities scheduled prior to the move.

5. Follow Up

Once an individual has transitioned to the community, the transition team maintains close communication and provides follow up as described in Division Directive 4.270. The Support Coordinator visits the individual weekly for the first 30 days. At a minimum, the transition team holds 30, 60, and 90 day review meetings. The transition team can be reconvened at any time needed to provide support to the individual and providers.

6. Additional Support

Prevention and planning are the most responsible and effective ways to address situations that may result in crisis or emergencies. The following resources may be utilized to assist individuals to successfully transition to the community:

- Consultation and assistance of Region Behavior Resource Team to assist support team to implement positive, preventative and proactive Tiered Support Strategies and assist to problem solve and resolve crisis situations
- Training by the Division including: Positive Behavioral Supports, Tools of Choice, Skills for improving relationships and behaviors, Person Centered Planning
- Training for support staff on the Transition Plan/Individual Service Plan (including the Behavior Support and Safety Crisis plans), crisis management skills, first aid and CPR, provider policies and procedures
- Training for support staff in recognizing the signs of escalating behavior and in responding to those with de-escalation strategies and physical management procedures such as MANDT, Nonviolent Crisis Intervention (NCI/CPI), Professional Crisis Management (PCM) or Safe Crisis Management (SCM)

- Development of meaningful day and positive support strategies in the Transition Plan/Individual Support Plan
- Identification of risks and development of strategies to mitigate through prevention, skill development or management of high risk situations
- Utilizing State Plan or Home and Community Based auxiliary services such as behavior analysis or behavior therapy services, crisis intervention services, or counseling
- Ongoing technical assistance by the Regional Office's Individual and Family Supports, Provider Relations, Behavior Resource Teams and Quality Enhancement staff
- Involvement of Regional Behavior Resource team to provide ongoing oversight and technical assistance to support individuals with high intensity support needs
- Consultation from District Chief Behavior Analyst

If all resources have been exhausted, and the individual is experiencing crisis which places themselves or others in imminent danger, Division Directive 4.190 provides procedures for the provision of short term crisis respite at a State-Operated Program campus.

This guideline will be reviewed and updated annually, if needed.